STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted],

Docket No. 2011-24460 ABW
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 42 CFR 431.200 et seq., following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] (the Appellant) appeared and testified on her own behalf. [redacted], appeared on behalf of [redacted], an Adults Benefit Waiver Plan contracted health care provider. [redacted] was present on behalf of the Department.

ISSUE

Did [redacted] properly deny prior authorization (coverage) for the prescription drugs Zolodex, and Lupron Depro?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, I find, as material fact:

1. The Appellant is enrolled in the Adult Benefit Waiver (ABW) program.

2. The Appellant seeks authorization (coverage) for prescription drugs, specifically Zolodex and Lupron Depro.

3. The medications sought are non-formulary medications.

4. The drug Lupron Depro is intramuscularly administered in a physician's office.

5. The Appellant's medical condition is not in dispute.

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> On January 16, 2004, the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, approved the Adult Benefit Waiver to permit the state to use state funds and funds authorized under Title XXI of the Social Security Act to provide coverage to uninsured adults who were not otherwise eligible for Medicaid or Medicare. The new program utilizes the Medicaid provider network and County-Administered Health Plans (CHPs) as managed care providers.
>
> The Adult Benefit Waiver I (ABW I), formerly known as the State Medical Program (SMP), provides health care benefits for Michigan's childless adult residents (age 18 through 64) with an annual income at or below 35 percent of the Federal Poverty Level (FPL). Covered services and maximum co-payments for beneficiaries in this eligibility category are detailed in the following sections. Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for the fee-for-service (FFS) beneficiaries enrolled in the ABW I program mirror those required for Medicaid. Only those providers enrolled to provide services through the Michigan Medicaid Program may provide services for FFS ABW I beneficiaries.
>
> ABW I beneficiaries enrolled in County-Administered Health Plans (CHPs) are subject to the requirements of the respective CHP. In those counties operating nonprofit CHPs, all covered services for ABW I beneficiaries (except inpatient hospital facility services) must be provided through the health plan. CHPs administering the ABW I program are required to provide the services noted in the Coverage and Limitations Section of this chapter to ensure that benefits are consistent for all ABW I beneficiaries across the FFS and CHP programs…CHPs may:
>
> - Require that services be provided through their contracted provider network, and, may institute prior authorization (PA) requirements beyond those required for the FFS ABW program.
>
> - Require beneficiaries to obtain certain services from the Local Health Departments (LHDs) or other community resources.

> When such referrals are made, the CHP is responsible for the beneficiary's share of the fee minus any applicable co-payments.
>
> CHP providers rendering services to ABW beneficiaries enrolled in a CHP are not required to enroll as providers in the Medicaid program, but they must comply with all Medicaid provider requirements as detailed in this manual. This includes the prohibition on balance billing beneficiaries for the difference between the provider's charge and the CHP reimbursement.
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> Medicaid Provider Manual, Adult Benefits Waiver I, Section 1, page 1, Version Date: January 1, 2006.

The Appellant is an ABW beneficiary. As such, she is entitled to only those services afforded to ABW beneficiaries. Coverage and limitations follows (entire list not included by ALJ):

> **SECTION 2 – COVERAGE AND LIMITATIONS**
>
> The table below outlines beneficiary coverage under ABW. Special instructions for CHP beneficiaries are noted when applicable.

Service	Coverage
Ambulance	Limited to emergency ground ambulance transport to the hospital Emergency Department (ED).
Case Management	Non-covered
Chiropractor	Non-covered
Dental	Non-covered.
Emergency Department	Covered per current Medicaid policy. For CHPs, PA may be required for non-emergency services provided in the emergency department.
Eyeglasses	Non-covered
Family Planning	Covered. Services may be provided through referral to local Title X designated Family Planning Program.
Hearing Aids	Non-covered
Home Health	Non-covered
Home Help (personal care)	Non-covered
Hospice	Non-covered
Inpatient Hospital	*Non-covered (Emphasis supplied by ALJ)*
Lab & X-Ray	Covered if ordered by an MD, DO, or NP for diagnostic and treatment purposes. PA may be required by the CHP.
Medical Supplies/Durable Medical Equipment (DME)	Limited coverage. • Medical supplies are covered except for

	the following noncovered categories: gradient surgical garments, formulas and feeding supplies, and supplies related to any noncovered DME item. • DME items are noncovered except for glucose monitors.
Mental Health Services	Covered: Services must be provided through the PIHP/CMHSP. (Refer to the Mental Health/Substance Abuse Coverage section of this chapter.)
Nursing Facility	Noncovered
Optometrist	Noncovered
Outpatient Hospital (Nonemergency Department)	Covered: Diagnostic and treatment services and diabetes education services. PA may be required for some services. A $3 copayment for professional services is required. * Noncovered: Therapies, labor room and partial hospitalization.
Pharmacy	Covered: • Products included on the Michigan Pharmaceutical Products List (except enteral formulas) that are prescribed by an MD, DO, NP or oral-maxillofacial surgeon. PA may be required. Products must be billed to MDCH or CHP, as appropriate. • Psychotropic medications are provided under the FFS benefit. (Refer to the MDCH Pharmacy Benefits Manager (PBM) website for a list of psychotropic drug classes to be billed to MDCH. Refer to the Directory Appendix for website information.) The list of drugs covered under the carveout is updated as necessary. Drugs are added and deleted on a regular basis so it is imperative that the provider review this website frequently. **Noncovered: Injectable drugs used in clinics or physician offices.** (Emphasis added by ALJ) Copayment: $1 per prescription
Physician **Nurse Practitioner (NP)** **Oral-Maxillofacial Surgeon** **Medical Clinic**	The following services are covered per current Medicaid policy: • Annual physical exams (including a pelvic and breast exam, and pap test). Women who qualify for screening/services under

	the Breast and Cervical Cancer Program administered by the LHD may be referred to that program for services as appropriate. • Diagnostic and treatment services. May refer to LHD for TB, STD, or HIV-related services, as available.

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[redacted] credibly established that she is seeking pain medications necessary to treat her medical condition. The Appellant had requested an alternative treatment for her condition, however that was not granted authorization, so she sought prior authorization for the pain medications.

The Department's witness established the drugs sought are not covered by the pharmacy guidelines contained in the Adult Benefit Waiver portion of the Medicaid Provider Manual. The Policy set forth above explicitly states intramuscular injections administered in a physician's office are not covered for ABW beneficiaries. Furthermore, Zoladex is not on the formulary; which is the listing of medications which may be covered for beneficiaries in this category of benefit level.

This ALJ is not unsympathetic to the Appellant's medical condition, ongoing pain or need for the medication sought. It is with regret this ALJ must uphold the determination made by the health plan as the authority of the ALJ does not extend beyond the stated legal parameters of controlling policy; nor does it extend to equitable considerations. The denial was legally proper, thus must be upheld by this ALJ.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I must find that [redacted] denial of coverage for the requested medications is appropriate, as in accord with current policy concerning coverage and limitations.

IT IS THEREFORE ORDERED that:

[redacted] denial of coverage is AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

[redacted]
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cc: [redacted]

Date Mailed: 5/25/2011

***** NOTICE *****

The Michigan Administrative Hearing System for the Department of Community Health may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System for the Department of Community Health will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the mailing date of the rehearing decision.